Redesigning Residential Treatment Facilities:
PACC Reform, Clinical Transformation and Preparing for Care Coordination
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EXECUTIVE SUMMARY

The New York State Coalition for Children’s Mental Health Services commissioned Manatt Health Solutions to undertake an impartial review of the statutory history, operating status and managed care preparedness of Residential Treatment Facilities (RTFs). RTFs are a subclass of hospitals licensed by the State Office of Mental Health to provide 24-hour, residential care to youth between the ages of 5 and 21. The catalyst for the review came from the 17 agencies that operate RTFs and are members of the Coalition, who were predicting that RTF operations are on a collision course with State policy. The Manatt study confirms that prediction, but suggests concrete and immediate reforms to maintain safe, responsive options for 24-hour, out-of-home treatment for severely emotionally disturbed youth and their families.

The Manatt review also attempts to reconcile the fact that New York’s RTFs have already begun transforming their operations in preparation for wide-spread managed behavioral healthcare approaches, with the inability to effectively complete the transformation. The findings site the following barriers: insufficient state investment into behavioral health technology, numerous years of rates freezes, the lack of oft-promised regulatory relief which leaves stifling, unfunded mandates in place decades after they were instituted and barriers to accessing necessary care and treatment.

As New York moves toward full implementation of its Medicaid Redesign Team goals, policy makers must act decisively to ensure the design of a healthy, sustainable children’s behavioral health care system is in place in every community. With reinstitution of the RTF rate methodology on July 1, 2013 and legislative authorization for transformational pilots at RTFs, the Coalition believes clinical reforms and necessary workforce re-training can continue the trend of reducing length of stay by the close of 2014. By allowing for capital reinvestments and Health Information Technology (HIT) supports, the Coalition believes RTFs can lead by linking children with more appropriate and more coordinated care after discharge. With regulatory review and reform, RTF admissions and discharges will be able to keep pace with shifting demands for reduced lengths of stay and more intensive treatment plans.

The Coalition invites careful consideration of the following action items to ensure every community in New York is equipped with an appropriate continuum of children’s behavioral health care services:

- Redesign the Pre-Admission Certification Committee process
- Increase flexibility in bed utilization and capacity through policy changes, such as average annual census approach
- Continue the 40% reduction in Length of Stay (LOS) achieved over the past 4 years by authorizing pilot projects that focus on worker re-training, staffing pattern changes and other clinical enhancements that will continue RTF transformation
- Identify fiscal policies that align incentives for RTF rightsizing and that support high quality, cost-effective care that is responsive to child and family needs.
SUMMARY OF FINDINGS AND RECOMMENDATIONS

1. **RTFs play a critical and irreplaceable role on the continuum of children’s mental health services for the relatively small percentage of children that require 24-hour structured care.** RTFs have already undergone a clinical transformation to address their 21st Century role, dramatically reducing their average length of stay, substantially enhancing their clinical and medication management capabilities and building stronger relationships with community-based resources. Nevertheless, if RTFs are to remain effective and viable elements of the children’s mental health system, a host of fiscal and regulatory policies need to be re-examined to ensure the clinical and financial sustainability of the RTF model.

2. **The Pre-Admission Certification Committee process must be redesigned.** The thirty-year old process of pre-admission review should be streamlined to ensure that decisions are made expeditiously and consistently and in a manner that reflects the evolving care coordination principles within the children’s mental health system.

3. **Reforms are also required within the current regulatory and fiscal policies that govern RTFs:** Regulatory reforms are necessary to provide greater clarity in the State’s approach to the future RTF bed capacity and greater flexibility in the deployment of RTF resources to meet children’s needs, including respite care. In addition, consideration should be given to test alternative payment policies that might better align incentives to encourage high quality cost-effective care, such as shared savings or episodic payment approaches.

4. **Resources must be identified to address the capital infrastructure of the RTFs to enhance the quality, safety and capacity of their services.** Reinvesting a share of the savings achieved from any potential downsizing of the children’s psychiatric hospitals into the capital needs of RTFs that will ensure they are better positioned to provide flexible, high quality and patient- and family-centered care, including investments in modern telehealth and other health information technologies.

5. **Additional support must also be identified to enhance and augment the clinical and family support staffing needs of RTFs.** To ensure that RTFs have the capacity to meet the needs of increasingly complex and challenging patients, investments will be required in psychiatric, nursing and other direct care staff, as well as in the necessary personnel to ensure successful “warm handoffs” back to their families, schools and communities. Strengthening the clinical capacity of RTFs will also require investments in training of staff in an array of areas, including peer mentoring, family support and telehealth services.
OVERVIEW AND BACKGROUND

Since the early 1980s, with the enactment of Chapter 947 of the Laws of 1981, Residential Treatment Facilities (RTFs) have provided fully integrated mental health treatment services to youth whose needs cannot be met in a community or less restrictive setting. These seriously emotionally disturbed (SED) youth, ranging in age from 5 to 21, are admitted to RTFs voluntarily, must have relatively stable symptomatology and may not present a likelihood of serious harm to others. Licensed by the New York State Office of Mental Health (OMH), RTFs provide 24-hour services and a structured environment one step below a psychiatric hospital in the continuum of mental health care services. The goal of the treatment is to reintegrate the youth into their families and schools and to help them learn to be safe and productive members of their communities.

Eighteen RTFs serve children within OMH’s five regions (Western, Central, Hudson River, New York City and Long Island). NYS RTFs range in size from 14 to 56 beds and together operate in excess of 500 beds. In 2008-2009, these 18 RTFs, plus one that has since been closed,\(^1\) accounted for nearly 192,000 bed days.\(^2\) Five pre-admission certification committees (PACCs), one in each of the OMH regions, are responsible for reviewing each application for admission to an RTF and determining applicants’ Medicaid eligibility and their appropriateness and priority for admission. The goal is to place youth in their region, but referrals can be made outside of region when appropriate services are unavailable.

Researchers site the absence of sufficient empirical evidence that might conclusively demonstrate the clinical effectiveness of RTFs.\(^3\) Nevertheless, it is widely recognized that “residential treatment is a treatment of choice, albeit a difficult one, when a young person is in need of a total 24-hour safe, structured environment to provide an array of appropriate and relevant services to address the severity of social, emotional and/or behavioral disorders.”\(^4\) Clinical evidence consistently links the success of residential treatment to family involvement during treatment and family and the broader community’s engagement in a child’s discharge.\(^5\) In New York State, RTFs have pioneered new and successful efforts to engage families and other support services from pre-admission to post-discharge, which have resulted in fewer re-admissions, lower lengths of stay and better outcomes for the children who required their care. New York’s RTFs have begun the transformation necessary to respond to providing care in a managed environment.

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1. Children’s Village, closed July 2012
2. Data obtained from the New York State Coalition for Children’s Mental Health Services
So, although research on the clinical effectiveness of RTFs is equivocal, the persons most familiar with the role of RTFs—the professional staff who oversee the programs and the family members who receive their support and services—view residential treatment and out-of-home placement settings as critical components on the continuum of mental health care for children: “an intervention, not a destination.” RTFs will play an increasingly important role in stabilizing the conditions of seriously emotionally disturbed children and easing their re-entry into their family, schools and community as pediatric and adolescent psychiatric hospital capacity for the most seriously emotionally disturbed children continues to diminish.

**CHALLENGES FACING RTFS**

*RTRSs are, however, at a crossroads. Consider the following:*

- RTFs remain subject to the same statutory and regulatory requirements that were put in place over thirty years ago and confront regulatory mandates that no longer align RTFs with their evolving roles in the children’s mental health system, despite numerous proposals for regulatory relief;

- RTFs have not received any increases in funding since 2008—no trend factors, no cost of living adjustments, no rate enhancements—even as expectations continue to escalate regarding the roles they should play for children and families, both pre-admission through the actual episode of care and thereafter, after the child has been discharged and is re-entering family and community life;

- Anticipated reductions in the capacity of the five current State-operated children’s psychiatric hospitals will inevitably result in increasing the number of children that may require RTF care, as well as increasing the complexity and severity of the emotional disturbances required to be addressed by RTF, which will require new investments in the RTF’s clinical capacity and staffing resources to meet these new demands;

- As the State embraces a care coordination/managed care approach to caring for children with severe emotional disturbances, RTFs remain largely unprepared for the demands of a managed care environment:

  - RTFs lack the required health information technology infrastructure to operate successfully in a coordinated care context, even though substantial state and federal support for HIT has been provided to many other sectors of the health care delivery system;

  - Flat reimbursement of RTF services leaves them unable to finance either the clinical or physical plant enhancements and revised staffing patterns and training that will be necessary to further reduce lengths of stay and improve the outcomes of care;

  - MCO reimbursement is particularly unlikely to provide adequate reimbursement for the necessary, ongoing capital expenses to allow RTF facilities to adapt and flexibly meet the needs of their current or future patient base;

  - A complex and cumbersome Pre-Admission Certification Committee (PACC) process cannot be easily reconciled with the utilization review and approval processes likely to be required by MCOs.

RTF operations are on a collision course with State policy. With diminishing in-patient psychiatric capacity for children, RTFs have been required to address the needs of children with increasingly more complex and profound emotional disturbances—and have been required to do so with state support that has not kept pace

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6 “Characteristics of Residential Treatment for Children and Youth with Serious Emotional Disturbances,” at 1.
with the costs required by RTFs to transform themselves. A consistent and sustainable re-investment strategy will be required by RTFs to allow them to recruit and retain qualified staff, deliver the clinical, educational and social interventions required by RTF clients, satisfy the regulatory requirements that govern RTF services and enhance the critical outreach that ensures a successful re-integration of children into their families and communities.

Moreover, evolving state policy will likely require RTFs to be navigating a managed care environment for which they are unprepared and ill-equipped and that cannot be reconciled with the current OMH and PACC regulatory construct. The demands of cost-effective coordinated care will require a reduced length of stay, greater coordination with the rest of the child’s physical and mental health needs, and an expeditious admissions and discharge process that will ease the transition of the child back to their families—outcomes that will be impossible to achieve without investments in the RTF infrastructure and delivery model as well as reform of the current PACC and related regulatory requirements.

Accordingly, Manatt was asked to undertake a review of the current regulatory and legal environment relating to RTFs, including the following:

- a review of the Pre-Admission Certification Committee (PACC) process to assess whether the pre-admission eligibility review can be streamlined and adapted to the evolving needs of a coordinated care system;
- a review of what other reforms and technological redesign may be necessary to improve care, reduce lengths of stay and respond to managed care principles;
- an analysis of the capital and staffing needs that may be required to support clinical and practice reforms that will more successfully re-integrate children in their families and communities.

Our conclusions have been shaped by a review of the current legal and regulatory environment, data and other information supplied by the New York State Office of Mental Health, a survey of the applicable clinical literature and group and individual discussions with the leaders in the children’s mental health services system in New York.

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**Design Recommendation to Improve NYS’s Approach for Early Identification, Service Excellence and Care Management for Children with Special Needs 10-23-12:**

The current behavioral healthcare system for children and their families is underfunded.

The confluence of MRT and State policy provides an opportunity to correct historically greater expenditures on chronic illness and behavioral health care for adults which far outweighs investment in children. The recommendations of the Children’s Workgroup presuppose the availability of adequate resources and reasonable utilization of children’s services. Strategic investments AND reinvestment of resources toward effective and coordinated children’s BH services is required. This recommendation is supported by the entire BH Subcommittee, including adult providers.

**and:**

A specialty behavioral health benefit for children should include family centered care coordination (Waiver, TCM, Health Home), wraparound, crisis intervention, transitional care, medication management, inpatient and outpatient treatment, day rehabilitation, peer support, respite, residential treatment, detoxification services, cross-system communication and coordinated case planning (reports to Family Court, status updates to foster care agency, juvenile justice program and/or school) and coordination with primary care.
The chart below summarizes the current complement of RTF services across New York State. Specifying the precise overall capacity of RTFs in New York State is not as easy as it may seem, as a result of a recent closure of an RTF (Children’s Village) and a number of other reductions or redeployment of beds that leave the total bed complement in somewhat of a state of flux. There are, in any case, approximately 516 RTF beds currently available in New York State, each with their own age and gender limitations and several with specialized units, as follows:

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<tr>
<td>Astor</td>
<td>20</td>
<td>Co-ed/Young</td>
<td>7,244</td>
<td>Hudson</td>
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<td>August Aichhorn</td>
<td>32</td>
<td>Co-ed/Teenagers</td>
<td>11,680</td>
<td>NYC</td>
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<td>Baker Victory</td>
<td>40</td>
<td>Co-ed/12-21</td>
<td>14,300</td>
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<td>Approved for new construction</td>
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<td>Children’s Home/ Stillwater</td>
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<td>Conners-Children &amp; Family Service</td>
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<td>Co-ed/6-14</td>
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<td>Crestwood</td>
<td>18</td>
<td>Co-ed/5-14</td>
<td>6,460</td>
<td>Western</td>
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<tr>
<td>Green Chimneys</td>
<td>14</td>
<td>Male/Adolescents</td>
<td>5,078</td>
<td>Hudson</td>
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<td>JBFCS/Goldsmith</td>
<td>50</td>
<td>Males/13-22</td>
<td>17,890</td>
<td>Hudson</td>
<td>Secure acute care center (“recovery unit”) on site with an additional 4 beds shared with Linden Hill males</td>
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<td>JBFCS/Iltleson</td>
<td>32</td>
<td>Co-ed/5-12</td>
<td>11,680</td>
<td>NYC</td>
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<tr>
<td>JBFCS/Linden Hill</td>
<td>64</td>
<td>Co-ed/12-21</td>
<td>22,894</td>
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<td>Hillside/Rochester</td>
<td>42</td>
<td>Co-ed/5-18</td>
<td>15,036</td>
<td>Western</td>
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<td>Hillside (FL)</td>
<td>40</td>
<td>Co-ed/12-18</td>
<td>14,604</td>
<td>Central</td>
<td>Incorporates 12-bed intensive RTF; building’s construction allows flexibility for gender configuration</td>
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<td>HGS</td>
<td>18</td>
<td>Co-ed/10-18</td>
<td>6,456</td>
<td>Central</td>
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<tr>
<td>SCO Madonna Heights</td>
<td>14</td>
<td>Female/12-21</td>
<td>4,856</td>
<td>Long Island</td>
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<td>SCO Ottlie</td>
<td>56</td>
<td>Co-ed/Adolescents and young adults</td>
<td>20,368</td>
<td>NYC</td>
<td>For dual diagnosis</td>
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<td>Parsons</td>
<td>20</td>
<td>Co-ed/12-16</td>
<td>7,276</td>
<td>Hudson</td>
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<td>St. Joseph’s</td>
<td>14</td>
<td>Male/13-21</td>
<td>4,862</td>
<td>Western</td>
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<tr>
<td>MercyFirst/ St. Mary’s</td>
<td>14</td>
<td>Male</td>
<td>4,660</td>
<td>Long Island</td>
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The RTFs rest on the continuum of children’s mental health services one step below inpatient psychiatric capacity for children and adolescents. The following are New York State operated children’s psychiatric hospitals:

- **NYC Children’s Center**: Bronx (75 beds); Queens (84 beds); Brooklyn (36 beds).
- **Rockland Children’s Psychiatric Center**: (54 beds)
- **Sagamore Children’s Psychiatric Center**: (69 beds)
- **Western NY Children’s Psychiatric Center**: (46 beds)

Additional inpatient psychiatric care is also provided by units at state operated psychiatric centers, and private psychiatric hospitals, licensed by the Office of Mental Health, and by general hospitals, licensed by the Department of Health, that may operate adolescent psychiatric inpatient units. 7

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**THE CURRENT LEGAL AND REGULATORY CONTEXT**

In order to explore how regulatory, statutory and fiscal policies may have to be reformed in order to transform Residential Treatment Facilities for children and youth ("RTFs"), it is essential to understand the current legal and regulatory requirements that govern RTFs. The following summarizes the laws and regulations governing RTFs, in general, and the Pre-Admission Certification Committee (PACC) process, in particular.

**Regulation of RTFs:** RTFs are residential facilities providing comprehensive mental health services under the supervision of a physician to children between the ages of 5 and 21 who are in need of long-term active treatment in a residential setting. 14 NYCRR § 584.1(b). RTFs are not intended for children who (1) present a likelihood of serious harm to others or (2) have a primary diagnosis of mental retardation or developmental disability. 14 NYCRR § 584.1(c); see also New York State Mental Hygiene Law (“MHL”) § 9.51(f). RTFs generally must have a capacity between 14 and 56 beds. 14 NYCRR § 584.5(e). RTFs in New York City may temporarily increase their capacity by up to 10 beds with the approval of the Commissioner of Mental Health. 14 NYCRR § 584.5(e). RTFs in a rural area may seek a waiver to allow a capacity of less than 14 beds, as may RTFs that wish to serve a specialized population. 14 NYCRR § 584.21(a)(1) and (b).

An RTF must have a governing body that meets at least quarterly. 14 NYCRR § 584.6(c). It has written plans and policies and procedures that address: admission, transfer and discharge, family involvement, services and staff composition, the quantity, quality, scope, goals, objectives and evaluation of all programs, a quality assurance plan, and a utilization review plan, prescription and administration of medication, and record keeping. 14 NYCRR § 584.6(d), (e); see also 14 NYCRR §§ 584.9, 584.17, 584.18.

Professional staff at an RTF must include the following: (i) nurse; (ii) occupational therapist; (iii) physician; (iv) psychiatrist; (v) psychologist; (vi) rehabilitation counselor; (vii) social worker; (viii) teacher; (ix) therapeutic recreation specialist; and (x) speech pathologist. 14 NYCRR § 584.10(d). There must be at least one full-time equivalent professional staff member for every seven residents, 14 NYCRR § 584.10(e)(3), and at least 25% of those individuals must include professionals with specified experience. 14 NYCRR § 584.6(f). With the permission of the Commissioner of Mental Health, an RTF may use (1) a physician in lieu of a psychiatrist.

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7 We are in the process of confirming the capacity of inpatient services for children and adolescents within the Article 31 private psychiatric hospitals and the Article 28 hospitals.
where a psychiatrist is unavailable in a rural area, or (2) a person with more general educational credentials in lieu of a therapeutic recreation specialist where such a specialist is unavailable. 14 NYCRR § 584.21(a)(2), (3). Each RTF must also have a qualified dietitian available on at least a consultation basis. 14 NYCRR § 584.6(h).

Services offered by an RTF must include specified mental health services, physical health services, educational and vocational services, and dietetic services. 14 NYCRR § 584.11. Mental health services must be provided directly by the RTF; others may be provided by written agreement with another provider. 14 NYCRR § 584.11.

Each resident of an RTF must be served by an inter-disciplinary treatment team responsible for developing and implementing an individual treatment plan for that resident. 14 NYCRR § 584.11(a); 42 C.F.R. §§ 441.155, 441.156(a). Each treatment team shall include at a minimum a psychiatrist, at least one member of the clinical staff who is assigned to the living unit on a daily basis, and at least one member of the professional staff responsible for providing verbal therapies, therapeutic recreation services; and education and vocational services. 14 NYCRR § 584.11(b)(1); cf. 42 C.F.R. § 441.156(c), (d). One member of the treatment team must be designated as case coordinator for the resident. 14 NYCRR § 584.11(b)(2).

Children may be admitted to an RTF where they (1) have a serious and persistent psychopathology, (2) have an intelligence quotient (“IQ”) of at least 51, (3) are between the ages of 5 and 21, (d) present no likelihood of serious harm to others. 14 NYCRR § 584.7(b). In addition, the RTF must find that (1) proper treatment of the child’s psychiatric condition requires care and treatment under the direction of a physician in an RTF, and (2) care and treatment can reasonably be expected to improve the child’s condition or prevent further regression. 14 NYCRR § 584.8(b); see also MHL § 9.51(d), 42 C.F.R. § 441.152. Additional admission criteria are possible, so long as they are based on “observable characteristics.” 14 NYCRR § 584.7(c). Discharge criteria must relate to the necessity and appropriateness of a child’s continued stay, and age by itself is not an appropriate basis so long as the child has not reached the age of 22. 14 NYCRR § 584.7(d).

**The PACC Process:** RTFs may only admit children who have been certified to the residential treatment facility by a pre-admission certification committee (“PACC”). 14 NYCRR § 584.8(a); see also MHL § 9.51(d), (e). There is a PACC associated with each of the five Office of Mental Health (“OMH”) regions (Western, Central, Hudson River, New York City and Long Island). 14 NYCRR § 583.5(a); see also MHL § 9.51(c).

The PACCs are appointed by the Commissioners of Mental Health, Health and Education; in so doing, the Commissioner of Mental Health must consult with the Conference of Local Mental Hygiene Directors and the Commissioner of Health must consult with county commissioners of social services. 14 NYCRR § 583.5(b), (c); see also MHL § 9.51(c). Members must include at least one psychiatrist or physician; other members may include nurses, psychologists or social workers, and all must have experience in the assessment and treatment of mental illness, preferably in the area of children and youth. 14 NYCRR § 583.5(d), (e); see also MHL §
9.51(c); 42 C.F.R. § 441.153. Members may not be affiliated with an RTF, but may be employees of the State of New York. 14 NYCRR § 583.5(f), (g); see also MHL § 9.51(c). Although there is no explicit provision in federal regulations that would preclude a member of the “team certifying need for services” from being affiliated with an RTF, the regulation does require that certification “must be made by an independent team.” 42 C.F.R. §441.153.

In four of the five regions, the PACC Coordinator serves as the OMH representative on the PACC. According to OMH, one region currently lacks a State Education Department representative and one is unavailable in the summer months. Two regions are without a representative of the Office of Children and Family Services (OCFS) or the local department of social services.

In identifying the team responsible for certifying a child’s need for services, federal regulation distinguishes between situations where an individual to be admitted is already enrolled in Medicaid, and where an individual applies for Medicaid while in the RTF. See 42 C.F.R. § 441.153. Where a child is already enrolled in Medicaid, certification must be made by a team that (1) includes a physician, (2) has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and (3) has knowledge of the individual’s situation. 42 C.F.R. § 441.153(a). Where a child applies for Medicaid while in the facility or program, the certification must be made by the interdisciplinary team of physicians and other personnel who are responsible for the individual’s plan of care. 42 C.F.R. § 441.153(b).

In undertaking the Medicaid eligibility process, the PACC and OMH acts like a local Medicaid office, making eligibility determinations for potential RTF patients. Known as “District 97”, the process requires that financial and disability determinations are made to assess the child’s eligibility for Medicaid support. If child meets the disability standard and is expected to be living apart from parental household for more than thirty days, the child’s financial eligibility is based on his or her own income and resources, which typically qualifies the potential patient for Medicaid. The disability standard is met if he or she has a medically determinable physical or mental impairment that results in marked and severe functional limitations that have or are likely to last 12 months or more. The determination can be made by a physician and other licensed professionals and must be signed by OMH personnel.

Each PACC must also have an advisory board of five members appointed by the PACC from recommendations made by the Commissioner of Mental Health in consultation with the Conference of Local Mental Hygiene Directors. 14 NYCRR § 583.10(b); see also MHL § 9.51(c). At least one member must represent each of the following stakeholders: (1) local government; (2) voluntary agencies; and (3) parents of children with mental illness. 14 NYCRR § 583.10(c); see also MHL § 9.51(c). The advisory board is charged with representing the interests of children in the region, and in so doing must (1) meet at least quarterly with the PACC, (2) review the monthly reports from the PACC, (3) identify in consultation with the PACC information that will be of assistance to the PACC, and (4) visit RTFs at the request of the PACC. 14 NYCRR § 583.10(a), (e).

The PACCs themselves must meet on a regularly-scheduled basis, and may meet in executive session to consider individual applications. 14 NYCRR § 583.7(a), (b). PACCs must maintain minutes of their meetings,
prepare an annual work plan, and submit a monthly report to the appropriate OMH regional director that will be made available to other governmental agencies. 14 NYCRR § 583.7(c)-(f). PACCs are responsible for (1) reviewing each application for admission to an RTF; (2) determining eligibility for such admission; and (3) certifying individual children as being a priority for such admission. 14 NYCRR § 583.3; see also MHL § 9.51(d). This includes an evaluation of the immediacy of the need of each child given the availability of services and the needs of the other children determined to be eligible who have not yet been admitted. 14 NYCRR § 583.6(a); see also MHL § 9.51(d). Each PACC is responsible for referring children for admission to RTFs in its region, but may refer children to another region when appropriate services are not available within its own region. 14 NYCRR § 583.6(b), (c); see also MHL § 9.51(d).

The eligibility criteria to be implemented by PACCs generally mirror those applicable to the RTFs themselves. Compare 14 NYCRR § 583.8(a) to 14 NYCRR § 584.8(b); see also MHL § 9.51(d); 42 C.F.R. § 441.152. In addition, a PACC may not make an eligibility determination unless it finds that available ambulatory care resources and other residential placements other than a hospital, do not meet the treatment needs of the individual child. 14 NYCRR § 583.8(b)(1); 42 C.F.R. § 441.152.

PACCs may receive an application for admission to an RTF from a parent or guardian, a director of a facility licensed or operated by OMH, the committee of a potential resident, a social services official or other person or organization having custody of a child, or the child himself/herself. 14 NYCRR § 583.9(a). The application must include parental consent unless otherwise permitted by law. 14 NYCRR § 583.9(a). Applications must include, at a minimum, assessments of the child’s psychiatric, medical, educational and social needs. 14 NYCRR § 583.9(c)(1). When necessary, the pre-admission certification committee is legally authorized to request and receive clinical information regarding the child that is maintained by any person or entity, and may refer a child to a hospital or other facility licensed or operated by OMH for additional assessment. 14 NYCRR § 583.9(c)(2), (3); see also MHL § 9.51(g). When an assessment is not available from a committee on the handicapped of the school district in which the child resides, the PACC is required to request one. 14 NYCRR § 583.9(c)(4). Such assessment must be provided within 30 days. 14 NYCRR § 583.9(c)(4). 8

PACC determinations of eligibility, immediacy of need and priority of placement must be unanimous. They must be made in writing, and must include the physician’s signature. 14 NYCRR § 583.9(e), (h). The PACC may refer the child to the PACC in another region when appropriate services are not available within the child’s own region. 14 NYCRR § 583.9(f).

The pre-admission certification committee must act in a “timely manner”; specifically, applications must be reviewed for completeness within seven calendar days of receipt, and once complete, eligibility determinations must be made within 30 calendar days, and written notice of such determination must be made within seven

8 Note that Department of Education regulations allow 42 days for response. 8 NYCRR § 200.4(h).
calendar days thereafter. 14 NYCRR § 583.9(l)(1)-(3). The PACC must issue notice to the referrer, child, and/or the child’s parent or legal guardian when: (1) additional information or assessments have been requested prior to making an eligibility determination; (2) an eligibility determination has been made; (3) a referral has been made to another PACC; or (4) a certification for admission has been made. 14 NYCRR § 583.9(k).

In addition, an RTF must provide written notice to the PACC and family/legal guardian within upon the occurrence of the following events: (1) the referral of a child as a priority for admission or transfer (notice must issue within 30 days); (2) a resident is ready for discharge or transfer (notice must issue 30 days in advance, if possible); (3) a resident attains the age of 21 (notice must issue within 30 days). 14 NYCRR § 584.8(c).

Eligibility must be reviewed every 60 days. 14 NYCRR § 583.9(l)(4). When admission of a referred child does not occur within 60 days after referral, the PACC must reconfirm its determination. 14 NYCRR § 583.9(i).

PACCS PROCESS AND PERFORMANCE

Even beyond these statutory and regulatory requirements, the PACC policies and procedures dictate, in detail, the steps that must be taken to secure admission at an RTF. A “Checklist of Supporting Materials for Pre-Admission Certification Committee Review” requires the preparation and documentation of the following even to commence the PACC review are the following:

- Referral Summary (including summary of the behaviors evidenced by the youth, self-care skills, ability to relate to others, along with a certification by a mental health professional as to the accuracy of the functional assessment);
- Psychiatric Summary (including the results of a recent (within past year and updated within the most recent 90 days) psychiatric examination, diagnosis, prognosis and medication summary);
- Psychological Summary (including an assessment of sensory-motor functioning, mental status, behavioral skills and deficits, IQ and prognosis);
- Physical Status (including the results of a general physical exam, dental/vision assessments, and, as appropriate, neurological and serological reports, x-rays and other findings, all within the past year or within the past thirty days if there is an ongoing medical issue);
- Psycho-Social Status (including a developmental history and an assessment of the child’s environmental/family/social status performed within the past year);
- Education/Vocational Summary (including an assessment of school status, vocational assets, test results, classroom behavior, any special education involvement, current work skills, etc., all undertaken within the past six months);
- Recreational Summary (including an assessment of recreational skills and experience, coordination, competitiveness and posture).

These assessments must be accompanied by a range of release and consent forms to permit sharing the information with the PACC and with the prospective RTF and to allow the PACC to undertake its Medicaid eligibility review. In addition, the referral packet should include the child’s birth certificate, immunization record, social security and Medicaid cards, among other documentation.
**Role of Single Points of Access (SPOA):** Even before the PACCs begin their review, the SPOAs—committees established by county mental health officials across the state to coordinate service delivery and access—are also directed to screen potential candidates for residential treatment before they are even considered by the PACC. In 2004, the SPOAs, which are not formally established by statute or regulation, were specifically directed by OMH to play a role in the RTF admissions process:

In the next several years, the vision is for the SPOA to act as a catalyst of coordination and the primary entry point into the local system of care for children and families needing services. In order to move closer toward that goal, OMH would appreciate your assistance in using the SPOA to screen potential candidates for residential treatment before they go to the RTF PACC (Preadmission Certification Committee). This does not mean the expectation is that the SPOAs will provide the same level of review as a PACC. It simply means that we expect the SPOA to ensure that before residential treatment is considered, every effort has been made to develop a plan for the child at the community level.  

While the precise process followed by the SPOAs may vary across the State, the guidance from OMH recommends that the Regional Office RTF specialist inform anyone who wishes to refer a child for a potential admission to an RTF “to contact the SPOA or County Mental Health Dept (LGU) of the county of origin and inform them of the intent to make a PACC application” and requires that “information from SPOA/LGU should be received prior to a PACC review.”  

The SPOA is expected to assess the child and family and consider whether lower levels of care may be sufficient to meet the child’s needs. In doing so, “the SPOA/LGU and the referent should provide the RTF Case Manager a description of the identified needs as well as the specific objectives to be achieved through the services available at the RTF” and should “also assess the family/care giver needs, skill development, etc. necessary for reunification and indicate the plan and local resources available to address family/care giver needs.”

As a result, two committees—the SPOA and the PACC—review the appropriateness of the RTF admission. The reviews are not entirely identical: the SPOA review is primarily focused on whether other community-based resources could be accessed or designed to meet the child’s needs, while the PACC determines whether the RTF level of care is appropriate and renders the Medicaid eligibility determination. Nevertheless, a number of the basic elements of the SPOA review mirror the determinations made by the PACC.

The experience of the State’s RTFs with SPOAs vary across the State. While no one disputes the need to assess whether community-based services have been fully evaluated before an RTF placement is made, some concerns have been raised over the potential that children may be forced to try and fail at various community-based services before accessing RTF care—in some cases, simply delaying the provision of the care that may actually be required. And, while many RTFs report successful and professional relationships with SPOAs,

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10 RTF Waitlist Management Timeline, August 30, 2005.
11 Id..
it is widely believed that some coordination, consolidation or streamlining of the two distinct reviews would expedite the referral process.

**PACC Waiting Lists:** In 1999, the Legal Aid Society in New York City filed a class action lawsuit that challenged OMH’s practice of maintaining extensive waiting lists of mentally ill children awaiting approval of PACCs for placement in RTFs. OMH had acknowledged, when the litigation was commenced, that approximately 400 children were awaiting placement in RTFs and that the “active waiting list” had contained an average of approximately 200 children for some length of time. See Alexander A., et al. v. Novello, et al., 210 F.R.D. 27, 31 (E.D.N.Y. 2002).

Although a class of children awaiting placement was certified by the federal court, the court denied a motion for summary judgment by the plaintiffs, holding that it was impossible to determine what ‘reasonable promptness’ [the applicable Medicaid standard\(^{12}\)] means in a case where the information available to the court is insufficient to ascertain what is involved in the process of matching a child with an appropriate RTF and developing other community-based services for RTF eligible and RTF-placed children, which defendants claim will decrease the length of time on the wait lists and offer better services under less restrictive conditions. In sum, at this point I am not persuaded of the soundness of plaintiffs’ legal position and of the defendants’ justifications for not creating additional RTF beds. *Id.* at 36-37.

The court referred the matter to a magistrate for settlement discussions and the preparation of a report on the issue of “reasonable promptness.” Faced with a waiting list that represented somewhere between approximately one-half or four-fifths of the entire existing RTF bed capacity, the court specifically directed the magistrate to consider the justifications offered by the State defendants for not creating additional RTF capacity.

The lawsuit was settled in 2005 with an agreement that children placed on the waiting list would receive an RTF placement within 90 days of certification. Although the court explicitly encouraged the opening of additional RTF beds for New York City children, no new permanent beds opened and, since that time, there has actually been a reduction in RTF capacity in New York State.

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\(^{12}\) “A State plan for medical assistance must . . . provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.” 42 U.S.C. §1396a(a)(8).
After the settlement, OMH prepared a “RTF Waitlist Management Timeline” that sought to address the waiting list issue and comply with the court settlement. The Timeline specified that it was only after the SPOA assessment was concluded and provided to the PACC that a child would be placed on the waitlist—with the understanding that, if an eligible child were unavailable for admission to a RTF for a period of time, the child’s eligibility would be suspended. The PACC process would commence, with the expectation that the referring party, along with the SPOA, would be assembling the necessary information for the PACCs review and with periodic contact of the referent along the way to ensure a prompt review. Once the information is updated, the RTF case manager would convene a conference call with the parents, SPOA representative, parent advocates, OCFS regional staff and an independent clinical consultant to re-assess the adequacy of alternative resources. The goal of the Timeline was presumably to make sure that the regional offices maintained the pace of the eligibility review to ensure that the ninety day timeframe for placement of eligible children was met.

According to a 2009 review of the impact of the litigation, the reduction of waiting lists was temporary.

Service providers say that instead, it became increasingly difficult to get children on the waiting list in the first place. “One way to not have a wait list is to provide services to anyone who needs them. Another way is to not approve anyone,” says James Purcell, chief executive officer of the Council of Family and Child Caring Agencies, the umbrella organizations that represents foster care agencies. “They’ve simply reduced the visible waiting list by not approving the applications.”

Current PACCs Practices and Productivity: In practice, according to RTF providers, each of the PACCs operates somewhat differently, particularly in the experience of those RTFs that relate to more than one. Many of the RTFs report very positive and professional relationships with the PACCs and the OMH RTF Coordinators across the State, developed through years of close interaction and collaborative problem-solving at the community level. In some instances, the relationships have been more strained, less transparent and more challenging.

According to OMH, because of its volume of cases, the New York City PACC convenes every three weeks, while the rest of the PACCs meet at least monthly. So-called “expedited reviews” may occur outside of the regularly scheduled meetings when RTF vacancies exist or are imminent. Expedited reviews may involve only the PACC physician member and the RTF specialist in the Regional Office and can take place over the phone and with faxed and emailed materials. No explicit regulations or policies govern expedited reviews and no data on the numbers of expedited reviews has been collected by OMH.

The volume of PACC referrals, reviews and approvals over the past decade is summarized on the attached table, which was provided by OMH. A few observations on the volume of PACC certifications:

- The most recent years’ numbers of reviewed cases ranged from between 263 to 302 cases in New York City to between 23 and 30 in Long Island—a greater than ten-fold difference in workload volume between two neighboring PACCs;
- Approval rates also diverged substantially among PACCs, with Long Island approving a consistently high percentage of cases in the most recent three years—averaging in excess of 85% over this time period—to the Hudson Valley’s approval percentages, which averaged only 56% during the same time period. The most recent year’s data is even more striking, when Hudson Valley approved less than half of the referred cases and Long Island approved 96 percent.
- The average statewide approval percentage remained reasonably consistent over the past decade, hovering between 56 and 64%;
- The total number of cases approved in 2008 through 2010 remained remarkably constant—389, 390 and 376, respectively—but increased substantially in 2011 to 426, the largest number approved over the past decade by far, reflecting presumably the results of reduced lengths of stay within the State’s RTFs.

**RTFS, PACCS AND MANAGED CARE**

The current process by which children access RTF services must be viewed against the backdrop of the ongoing Medicaid Redesign Team discussion of the implementation of a care coordination strategy for children with behavioral health needs.\(^{14}\) The draft plan for how children with serious emotional disturbances might access care envisions the following:

- Children with behavioral health needs would be enrolled in mainstream Medicaid managed care plans;
- The plans would be required to contract with “qualified specialty entities” that would be responsible for providing the full array of behavioral health services, as well as coordinating those services with the rest of the child’s medical care;
- The qualified specialty entity would, in turn, contract with children’s specialty providers and networks to provide the full array of behavioral health care services;
- These behavioral health care services would include residential treatment facility and other residential services, as well as inpatient and outpatient behavioral health services, case management/care coordination, health home and waiver services, peer support, medication management, among other services.

While many details and timelines remain to be decided, the general direction is clear: arranging and paying for RTF services will become the clinical and financial responsibility of managed care plans and qualified specialty entities.

One result of these recommendations will be to reconcile the utilization review and care coordination responsibilities of these managed care-related organizations with PACCs and SPOAs. Not only will the introduction of additional gatekeepers create the virtual certainty of additional delays, the prospect of conflicting or inconsistent decisions by these multiple entities. In short, how will we coordinate the care coordinators?

POLICY RECOMMENDATIONS FOR RTF TRANSFORMATION

Before considering the necessary policy choices that might facilitate the transformation of RTFs to serve children with more complex conditions and to do so with greater cost-efficiency and effectiveness, it should be noted that the transformation of RTFs is already well underway. RTFs are pioneering new efforts to provide more significant levels of clinical and program services to their patients and to transition them more quickly and effectively back to their families and communities.

According to data compiled by the New York State Coalition for Children’s Mental Health Services, average lengths of stay in RTFs have decreased from 656 days in 2008 to 470 days in 2012-13—a forty percent reduction in just four years. Several RTFs have seen lengths of stay generally drop to approximately one year and some to even shorter durations. Most anticipate that lengths of stay could average between nine months and a year—particularly with the benefit of some of the funding and policy changes described below.

Recommendations for Reform of PACC Process: While the increasing volume of cases reviewed and referred by PACCs is encouraging, it remains unclear whether the existing PACC process could keep pace with a drive toward an ever-diminishing length of stay and a concomitant growth in the number of children who may require RTF care as psychiatric hospital capacity continues to downsize. As noted, moreover, determining how SPOAs, PACCs and the prior approval processes of behavioral health/managed care organizations might be reconciled requires a serious rethinking of the PACC process.

For simplicity sake, if we assumed that RTFs reduced LOS to one year—a dramatic reduction in LOS, but one that many RTFs believe they can achieve or surpass—and there was a relatively modest increase in the numbers of children requiring RTF care, the PACCs would have to approve roughly 516 cases (the current total bed capacity) per year to avoid vacancies that could undermine the financial viability of the RTF programs. That would require that PACCs approve twenty-one percent more referrals during the course of the year than their 2011 record-breaking pace. If one assumed that LOS needs to be reduced to an even lower number, perhaps to nine months, PACCs would have to approve approximately 688 placements per year—or an over sixty percent increase over their 2011 level of activity.15

15 While it may be questioned whether there would, in fact, be that many children that required and were appropriate for RTF care in a given year, most RTF providers believe that sufficient unmet need exists to warrant that volume of RTF admissions, given the need to meet the needs of children in settings other than inpatient hospitals, particularly as inpatient beds decline, the existing (whether acknowledged or unacknowledged) waiting lists for admission and the potential for some re-admissions of children, even for brief periods of time, that might be required if shorter lengths of stay prove not to be entirely successful in addressing the child’s underlying condition.
Many of the recommendations below, therefore, are oriented to making it more likely that the PACC process operate more efficiently and effectively as the principal gatekeepers to RTFs, particularly with regard to coordinating their practices with the other entities and their gatekeeping roles.

- **Streamline the PACC review process:** As described above, the process of PACC review is a complicated one that has only become somewhat more elaborate in recent years as a result of the waiting list litigation and the introduction of SPOA review. We would recommend, as an initial step, a comprehensive review by OMH and stakeholders of the policies and procedures governing PACC procedures, along the lines of a Lean Six Sigma review, to identify steps and processes that might be made more efficient, focusing on how best to achieve its specific goals.

- **Formalize the “expedited review” process:** Although the expedited review process has been employed by PACCs, nothing in the statute or regulations expressly authorize the expedited review process and, in the experience of RTFs, the availability of expedited reviews has not been consistent across PACCs. We would recommend consideration of legislation to amend the PACCs process to require expedited reviews whenever there is a vacancy or anticipated vacancy in RTFs.

- **Centralize the “District 97” Medicaid eligibility process:** PACCs, as noted above, perform two distinct functions: in addition to affirming that the placement of the child in a RTF is clinically appropriate, the PACC must also make the necessary disability and related determinations to confirm the child’s eligibility for Medicaid. While discussion occurred as to whether to centralize the entire PACC process at the statewide level to achieve some efficiencies and greater consistency in the admissions process, most RTFs and other stakeholders viewed the regional assessment and approval of admissions to be a positive and necessary element of the pre-admission review and recommended retaining the regionally-based clinical review. Consideration should be given, however, to consolidating the District 97 Medicaid eligibility reviews at the OMH Central Office, thereby allowing the PACC itself to focus on the clinical assessments.

- **Coordinate the PACC and SPOA review processes:** As part of the review of the PACC process, consideration should also be given to reconciling the roles of the SPOA and the PACC, incorporating the local governmental unit and the “less restrictive alternative” assessment into the PACC process without essentially duplicating the review.

- **Establish clearer criteria for PACC review and an “appeal” or reconsideration process to ensure consistency and fairness:** In the absence of more express criteria and greater transparency in the review process (subject, of course, to the appropriate levels of confidentiality that must be observed), the process of PACC review sometimes appears to be arbitrary and potentially uneven. Absent the availability of a formal review or appeal process, the opportunity to test whether the PACC review focused on the appropriate criteria is lost. To the extent that the process remains immune from review, RTFs have sometimes wondered what may have been the cause of periodic or sustained delays in receiving referrals from a PACC.

- **Strengthen family and RTF involvement in PACC process and enhance the communication between RTF providers and PACC regarding potential referrals:** While it is understood that the PACC decision-making process must be undertaken without direct RTF or family involvement, enhancing the level of communication and transparency between PACCs and the RTFs, on the one hand,
and families, on the other, would improve the process. RTFs should be informed, at the earliest possible opportunity, of the potential referral to begin the necessary outreach and assessment to ensure that the RTF intervention is as successful as possible. RTFs should be required to provide the PACC with updates on the vacancies and imminent vacancies and should receive more complete information on prospective referrals. The development, with state support, of the necessary health information technology and electronic medical record capacity within the RTFs could be essential to ensure that the RTFs and PACCs can communicate in real time to facilitate successful transitions of children in and out of residential care.

- **Reconcile the PACC process with the utilization review and prior approval processes of managed care organizations/qualified specialty entities:** Even after reforms are enacted in the PACC process itself, efforts must be undertaken to accommodate that process with the evolving managed care initiatives for children with serious emotional disturbances. As a first step, we would recommend convening OMH, PACC, RTF and managed care stakeholders to examine how we might ensure that the various gatekeepers—PACC, SPOA, managed care/potential qualified specialty entities—do not undertake duplicative and potentially inconsistent review and approval procedures.

### RTF REGULATORY AND PAYMENT REFORM

- **Greater clarity in State’s approach to RTF bed capacity and future needs:** Particularly in the aftermath of the closure of an RTF after a prolonged decline in PACC-approved referrals, RTFs have sought to confirm OMH’s longer-term view of RTFs and their role in the children’s mental health system. It is also generally assumed that OMH wishes to reduce RTF capacity, generally, and beds for the youngest cohort, specifically, but there does not appear to be any clear planning goal for RTF capacity on which providers, local governments or consumers might rely. Instead, ad hoc, provider by provider negotiation has ensued in recent years between OMH and RTFs, resulting in bed reductions in certain cases and the outright closure of an RTF. In the absence of an explicit State RTF resource planning process, concerns have been raised over whether the State may be seeking to accomplish these unstated goals through some manipulation of the referral process or by freezing reimbursement to require contraction of RTFs. The better approach would be to engage in a frank, data-driven discussion on the need for RTF capacity, region by region, cohort by cohort and to implement a transparent strategy to increase or decrease capacity in accordance with the identified need for these services.

- **Increased flexibility in bed utilization and capacity, such as average annual census policies and conversion of beds to alternative purposes:** To respond to evolving needs that may emerge on a regional basis, some degree of flexibility in expanding or contracting services by RTFs should be examined, which would allow the admission of children within some corridor of the overall approved capacity of facility, subject to the availability of appropriate residential capacity. The concept of “average annual census” as a guide to allowing some flexibility in daily census should be considered. Consideration should also be given to allowing the conversion of beds to more specialized and intensive service delivery, as well as allowing the use of RTF beds for brief respite purposes for former patients during their re-entry transition.
• **Explore fiscal policies that align incentives for RTFs and encourage high quality cost-effective care:** To encourage lower lengths of stay and to allow additional resources to be available to ensure the delivery of more cost-effective care, consideration should be given to experimenting with alternative reimbursement methodologies. Demonstration projects might authorize the payment of a fixed “episodic” payment for the course of a child’s care in an RTF (reflective of the severity of the child’s condition, but not determined by the number of days of care) or reconfiguring reimbursement policies to allow for some sharing of savings between the RTF provider and the State if lengths of stay are reduced. Consideration may also be given to establishing a quality incentive pool, which would provide additional payments to providers that achieve certain pre-determined outcomes, including reduced post-discharge re-admission rates or meet other quality standards.

**RTF CAPITAL REINVESTMENT INITIATIVE**

The continuing efforts to downsize state-operated inpatient capacity carry with them both challenges and opportunities: any reductions in state children’s psychiatric center capacity will require RTFs to address the more complex needs of children who might otherwise have been hospitalized, but will also free up resources that can be utilized to better equip RTFs to meet these challenges. To take advantage of whatever regulatory flexibility might be achieved and to prepare RTFs for their emerging role in the mental health continuum, the State should consider reinvesting resources saved from diminishing the state’s inpatient capacity for the following:

- **Reconfiguring space to reduce unit sizes to four beds, to add intensive treatment/crisis units and to reconfigure beds to support average annual census policy:** Capital investments are necessary to ensure that RTFs can flexibly respond to children’s needs and to be nimble enough to expand or contract capacity, depending on the community’s needs.

- **Enhance safety compliance, expand intake and discharge space to keep pace with expedited turnover of patients, and expand vehicle fleet to address community/family outreach:** Part of the current challenges recounted by RTFs is the need to be much more connected to the child’s family— which, in some cases, may reside some considerable distance from the RTF. Successfully re-integrating the child back to his or her community, as well as fulfilling the goals of the Building Bridges Initiative, described below, requires persistent and closer contact with the child’s family. As a result, facilities require the physical capacity on-site to accommodate sufficient intake and discharge activities and sufficient transportation resources to retain close relationships with the child’s family.

- **Establish health information technology capacity, including telehealth capacity, and reconfigure space for lifeskills and assessment needs.** Although New York State has invested tens of millions of dollars in health information technology in virtually every other element of the health care sector, behavioral health providers have received none of it. Integration of the child’s health and behavioral health services, accessing increasingly scarce pediatric psychiatric and neuro-psychological expertise, expediting and improving the admission and discharge processes, and undertaking appropriate follow-up monitoring of the child’s progress would all be substantially enhanced by the implementation of electronic records, telehealth and other elements of health information technology.
RTFS AND CLINICAL TRANSFORMATION

To address the increasing complexity of the children they serve and to provide successful and cost-effective transitions back to the community, a number of additional investments will need to be made in workforce retraining and staffing patterns. Among the initiatives that reflect these new imperatives is the Building Bridges Initiative (BBI), which was launched in 2005 to strengthen partnerships between community- and residential-based treatment and service providers, policymakers, advocates, families, and youth, and to generate an effective approach for all service providers. BBI offers a framework for shared values and best practices to achieve results such as community partnerships, reduced lengths of stay, and increased youth and family engagement, skills, and satisfaction. To meet the goals of responding to the BBI objectives and to otherwise enhance RTF care, a series of clinical enhancements will be required, including:

- Additional psychology/psychiatry/nurse practitioner resources
- Expanded clinical staff for ITU and crisis units
- Additional direct care staff to address reconfigured space
- Significant investments in permanency planning/family connections to strengthen transition efforts that would fulfill the Building Bridges and similar initiatives
- Additional intake/discharge staffing
- Youth/peer transition partnerships
- Creating the sanctuary model
- Training in a wide array of areas, including life skills, peer mentoring, TFCBT, ABA, intensive DBT, Telehealth, regulatory and compliance, DD population, sensory integration, advanced crisis avoidance

CONCLUSIONS AND NEXT STEPS

The New York State Coalition hopes that policy makers take the downward trend in the number of child and adolescent psychiatric beds around the state seriously. We welcome the ability to identify strong, cost-effective responses to general, private and state-operated inpatient psychiatric bed downsizing in conjunction with state officials. Appropriate responses must include a mix of community-based and out-of-home children’s behavioral health services that must be adequately resourced. The stagnation in reimbursement, across-the-board rate freezes and lack of cost of living adjustments cannot ensure safe, high quality care. For this reason, we urge that any Medicaid resources removed from the state-operated children’s behavioral health system be reinvested into alternative children’s behavioral health services.

In this report, we focus on the regulatory and clinical reforms necessary for RTFs, but we understand that making the necessary resources available to finance reform may require system right-sizing. For this reason, The Coalition also supports the decision by individual provider agencies to adjust the size of their RTF operations in exchange for the authority to transform the remaining RTF services into the most responsive, highest quality clinical services available.

The Coalition’s member agencies have already begun necessary transformation, but widespread support and action is necessary to complete the restructuring envisioned by the children and families we serve.

16 For more information, see: http://www.buildingbridges4youth.org/index.html
To download this report go to: www.cmhny.org